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CONNECTICUT OFFICE OF  
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# **State of Connecticut** **Office of Health Care Access** **Letter of Intent/Waiver Form** **Form 2030**

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All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HGA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

## **SECTION I. APPLICANT INFORMATION**

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	Marc B. d'Avignon, MD, PC	
Doing Business As	Farmington Valley MRI, LLC	
Name of Parent Corporation		
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	23 B Arts Center Court, Avon, CT 06001	
Applicant type (e.g., profit/non-profit)	For Profit Professional Corporation (PC)	
Contact person, including title or position	Suzanne Berwick, BS Practice Administration	
Contact person's street mailing address	40 Dale Road Avon, CT 06001	
Contact person's phone #, fax # and e-mail address	860-677-5082 860-677-2713 xray1993@aol.com	

## SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title: Replacement of Existing MRI

b. Type of Proposal, please check all that apply:

X Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> New (F, S, Fnc)       | X Replacement                          | <input type="checkbox"/> Additional (F, S, Fnc)      |
| <input type="checkbox"/> Expansion (F, S, Fnc) | <input type="checkbox"/> Relocation    | <input type="checkbox"/> Service Termination         |
| <input type="checkbox"/> Bed Addition          | <input type="checkbox"/> Bed Reduction | <input type="checkbox"/> Change in Ownership/Control |

☒ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☐ Project expenditure/cost greater than \$ 1,000,000

☒ Equipment Acquisition greater than \$ 400,000

- |                                  |   |  |
|----------------------------------|---|--|
| <input type="checkbox"/> New     | <input type="checkbox"/> Replacement        | <input type="checkbox"/> Major Medical |
| <input type="checkbox"/> Imaging | <input type="checkbox"/> Linear Accelerator |  |

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over \$1,000,000

c. Location of proposal (Town including street address): 23 B Arts Center Court, Avon, CT 06001.

d. List all the municipalities this project is intended to serve: Avon, Burlington, Canton, Granby, New Hartford, Simsbury, Torrington and West Hartford.

e. Estimated starting date for the project: May 2006

**Major Medical and/or Imaging equipment acquisition:**

Equipment Type	Name	Model	Number of Units	Cost per unit
GE Signa	1.5	GE Excite	1	\$895,000.00

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

- ☒ Applicant's Equity      ☒ Lease Financing      ☐ Conventional Loan  
☐ Charitable Contributions      ☐ CHEFA Financing      ☐ Grant Funding  
☐ Funded Depreciation      ☐ Other (specify): \_\_\_\_\_

**SECTION IV. PROJECT DESCRIPTION**

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2-page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

- Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
- What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
- Who is the current population served and who is the target population to be served?
- Identify any unmet need and how this project will fulfill that need.
- Are there any similar existing service providers in the proposed geographic area?
- What is the effect of this project on the health care delivery system in the State of Connecticut?
- Who will be responsible for providing the service?
- Who are the payers of this service?

## **SECTION IV PROJECT DESCRIPTION:**

✓ Marc B. d'Avignon, M.D. is a licensed Physician & Surgeon, State of Connecticut and is Board Certified in Diagnostic Radiology with Special Competence in Nuclear Radiology by the American Board of Radiology. Marc B. d'Avignon, M.D. has been in solo practice in Avon dba Westwood Imaging Center for over 17 years.

Marc B. d'Avignon, M.D., P.C. is the sole owner of Farmington Valley MRI, L.L.C. (FVMRI), 23B Arts Center Court in the Town of Avon and is responsible for providing the service. FVMRI serves the Towns of Avon, Burlington, Canton, Granby, New Hartford, Simsbury, Torrington, and West Hartford. FVMRI payors include Medicare/Medicaid and HMO/third party providers licensed in Connecticut such as Anthem BC/BS, Aetna, Connecticare, Cigna, Oxford, among many others.

There are two other MRI units in Avon, one a fixed GE 1.0T MRI located on Route 10 and the other a Mobile GE 1.5T MRI located on Nod Rd.

FVMRI is an accredited facility meeting all of the requirements and standards of the American College of Radiology. The GE 0.5T MRI was installed in 2001 and was under \$400,000.00 and therefore did not require a CON (Letter of Intent 00-Z1).

The GE 0.5T MRI is now over 10 years old and has reached 'end of life' use. GE is no longer manufacturing parts and is supporting maintenance only on an "as available" basis resulting in increasing down time and patient inconvenience.

Marc B. d'Avignon, M.D., P.C. respectfully proposes replacement of current GE 0.5T MRI with a permanent used GE 1.5 Signa Excite MRI. Said replacement would upgrade existing diagnostic capabilities and assure more predictable operation and maintenance schedules, thus providing a greater standard of patient care.

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f. Type of project: 19 (Fill in the appropriate number(s) from page 7 of this form)

**Number of Beds (to be completed if changes are proposed)**

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
N/A				

**SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION**

a. Estimated Total Capital Expenditure: \$60,000.00

b. Please provide the following breakdown as appropriate:

Construction/Renovations	\$ 60,000.00
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	(Included)
Delivery & Installation	
<b>Total Capital Expenditure</b>	<b>\$ 60,000.00</b>
Fair Market Value of Leased Equipment	895,000.00
<b>Total Capital Cost</b>	<b>\$955,000.00</b>

**If requesting a Waiver of a Certificate of Need, please complete Section V.**

**SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT**

I may be eligible for a waiver from the Certificate of Need process because of the following:  
(Please check all that apply)

- X This request is for Replacement Equipment.
- X The original equipment was authorized by the Commission/OHCA in Docket Number: 00-Z1
- X The cost of the equipment is not to exceed \$2,000,000.
- X The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

**AFFIDAVIT**

Applicant: Marc B. d'Avignon, M.D., P.C. \_\_\_\_\_

Project Title: Replacement of Existing MRI \_\_\_\_\_

I, Marc B. d'Avignon, M.D., President and CEO of Marc B. d'Avignon, M.D., P.C. being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that Farmington Valley MRI, L.L.C complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Marc B. d'Avignon  
Signature

01/27/06  
Date

Subscribed and sworn to before me on January 27, 2006

Gail E. O'Connor  
Notary Public/Commissioner of Superior Court

My commission expires: \_\_\_\_\_  
**Gail E. O'Connor**  
**NOTARY PUBLIC**  
**State of Connecticut**  
**My Commission Expires 9/30/2009**

## Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

### Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

### Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Abuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

### Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical